REMARKS OF

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SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT

BEFORE

THE AMERICAN SOCIETY OF HOSPITAL PHARMACISTS

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Thank you for inviting me to join you today. It is a pleasure to meet with you to discuss the future of health policy and the health politics of the 100th Congress.

This is an opportune time to have this discussion, since the House and the Senate budget committees are still in conference, trying to reach agreement on the fiscal year 1988 budget resolution. The outcome of their deliberations will drive our health policy deliberations for the remainder of the year, just as it has for the last six years.

The conference decisions will be hard: The Senate numbers for health are even more stringent than the House. In the case of Medicare, for example, the House resolution calls for a reduction of $1.5 billion next year, while the Senate resolution calls for a reduction of $3 billion. Neither alternative is a happy one. It pains me -- as someone interested in health care -- that the best outcome that we can hope for from the budget is not progress but just another year of limiting losses.

I wish we could make health policy without thinking first of budgets. Sometimes, in fact, it seems that we think only of budgets. would prefer that, in this Congress, we placed greater emphasis on formulating a national health policy agenda that responded to our most pressing health problems.

I am somewhat encouraged in that many of my colleagues, as well as large numbers of the general public and many of the interest groups, do seem to be aware that the task of addressing our health problems has been neglected, that budget cuts have eroded our programs, and that a more balanced approach to budget politics is needed.

We are not, however, getting much encouragement from the President. Once again, the President has demanded that we short change the Nation's public health. The cuts he calls for are the largest of all.

REAGAN HEALTH BUDGET

Despite the thirty-seven million people in this country with little or no health insurance, despite the thirty thousand Americans with AIDS and the millions more at risk of getting this disease, despite our relatively high national infant mortality rate, and despite an aging and disabled population in growing need of home and community-based services, this Administration has again proposed a health care budget that is irrational and irresponsible.

Under the Reagan proposal, $85 billion would be stripped away from Federal health care programs over the next five years. In articular:

-- Medicaid expenditures would be cut by $1.3 billion in the first year alone, and the entitlement nature of the program would be undermined;

-- Medicare payments would be reduced by $5.1 billion during the fiscal year 1988;

-- Public health programs that protect against diseases which can be cured such as tuberculosis, and that promise results for diseases such as AIDS whose cures are not yet known, would be funded inadequately;

-- Biomedical research would be curtailed and health services would be unavailable to many of those most in need.

Such proposals are unreasoned and unreasonable. They reflect neither the values of the American people nor the views of public health experts. We will do all that we can to oppose them, but we face an uphill battle.

CATASTROPHIC HEALTH COVERAGE

It is important to keep the Administration's budget-cutting agenda in mind, as we discuss proposals for catastrophic health care.

Let me say from the outset that I attach great political significance to Secretary Bowen's proposal. With the President's endorsement, catastrophic health insurance is now firmly on the legislative agenda. For the first time ever, this Administration has recognized the need for improved coverage, and its proposal represents the minimum we can expect to be enacted.

But the Reagan plan is misleading and essentially hollow.

None of the thirty-seven million Americans without health insurance will benefit from this plan. None of those in need of nursing home or other long-term care services will benefit from this plan. None of the people facing large prescription drug costs will benefit from this plan. Indeed, of the thirty-one million Medicare beneficiaries -- the only group for whom the Bowen program was designed -- only one of every twenty-five will be helped.

Yet, this proposal is being portrayed by the Administration as an answer to the financial disaster that is brought on by serious illness. It is true that the plan provides some help with acute health care costs. But it is also true that the plan does not address the health costs that trouble elderly Americans most:

-- Hospitals are discharging patients more quickly and in greater need of home and community-based care. No provision is made for assistance after a patient leaves.

-- The Administration itself has acknowledged that long term care and nursing home costs are some of the most disastrous effects of catastrophic illness. Yet neither the Medicare program nor the Administration plan contains any real nursing home benefit, and the Administration proposal gives us no help in planning for the future needs in addressing this problem.

Elderly Americans will still be left with the harsh reality that the only way to get help with nursing home care is to impoverish themselves to the level of Medicaid eligibility, often leaving a spouse impoverished as well.

-- The high costs of prescription drugs, often as expensive as medical treatment, are not addressed. As you well know, Medicare does not pay for out-patient prescription drugs.

-- And the out-of-pocket share of many high physician bills are not dealt with at all by the President's proposal, no matter how high they may mount.

The Bowen plan is, then, just the starting point. I welcome the Administration's push for reform, but we must now look to the Congress to take the real leadership role in creating a plan that can honestly be called insurance against catastrophic illness.

Recently the Congress took a strong first step in this direction. The House Ways and Means Committee reported a catastrophic health insurance bill, with a number of significant improvements over the Administration's proposal.

This bill comes because of the strong effort and leadership of my colleague Pete Stark. He has improved on the acute care provisions in the Administration bill. He has crafted a bill that will assure that Medicare beneficiaries pay no more than one hospital deductible per year. He has made improvements in home health coverage -- including a proposal that I have sponsored in the last several Congresses to address the intermittent care problem. And his financing is more progressive than the Administration's.

The Ways and Means proposal will be paid for by a small increase in the base premium that Medicare beneficiaries pay, plus a supplemental premium depending on income and determined by a table on the tax form.

The bill will now come over to the Energy and Commerce Committee and I look forward to working on it.

PRESCRIPTION DRUGS

As many of you know, I have been concerned about the dramatic and continuing price increases for prescription drugs. In particular, we have been investigating whether the reasons cited by the drug industry for these price increases have any basis in fact.

When the Subcommittee held hearings in July, 1985, to examine prescription drug price increases they were rising at a rate roughly twice that of the Consumer Price Index. Also, at that time, witnesses for the drug industry told us that increases of that magnitude were only a temporary phenomenon. As it turns out, they were right -- today, drug prices outstrip the CPI by far more than they did then. Since July, 1985, the CPI has risen by 2.7%. Prescription drug prices have risen 12.2% -- a record 4 1/2 times greater than the CPI.

The industry claims these price increases are essential if research and development is to be expanded. This is a rationale that we now have investigated thoroughly. Based on data supplied to the Subcommittee by the leading 25 manufacturers, it's clear that the pharmaceutical industry has misled the American people. Most of the money generated by the recent enormous price increases is not going to fund R & D.

Between the years 1982 and 1986, drug price increases produced revenue gains of $4.7 billion. During the same period, R & D xpenditures rose only $1.6 billion -- or about a third of the revenue gains from price increases.

We need to know what's going on with the drug industry. Too many Americans depend on life-saving drugs for Congress to let prices skyrocket without a clear justification from the companies involved. And, we must constantly remember that most Americans get drugs only one way -- by paying for them out of their own pockets. Only a small fraction of the drugs consumed in the United States gets paid for by the government or by health insurance.

This particularly affects the elderly, most of whom live on fixed-incomes. While they constitute 11 percent of the population in :his country, they consume roughly 30 percent of the drugs prescribed each year. The elderly are upset and concerned about the prices they pay for drugs.

Drugs are important to our health. We must guarantee that they are denied to no one simply because they cost too much. As many of you know, I believe that any catastrophic program under Medicare must include prescription drugs. Currently, Medicare beneficiaries are paying enormous amounts of their own money for prescribed drugs, with no assistance from Medicare. Well over 10 percent of them pay more than $400 a year for drugs.

These drugs are needed to treat such chronic and disabling conditions as arthritis, diabetes, and heart disease. Their cost is ncreasing at unprecedented rates. And they are needed for a lifetime.

No elderly or disabled person should have to choose between paying for medications and other daily necessities; nor should they have to spend all their savings on drugs to avoid more serious illness and, perhaps, a catastrophic spell in a hospital or a nursing home.

I have held a hearing on a bill I introduced that provides catastrophic coverage for prescription drugs under Medicare. I am pleased that, at the same time as the Ways and Means Committee reported its catastrophic health insurance proposal, Chairman Rostenkowski also committed himself and the committee to working with us to create such a drug benefit. I believe that, working together, we will be successful in including this provision in the bill that the House will consider.

Our bill incorporates a major professional role for pharmacists. Central to our approach is the notion of "participating pharmacists." They would be called on to help Medicare beneficiaries determine when they had reached the catastrophic limit of $400. They would counsel beneficiaries on the availability and appropriate use of generic drugs. And they would provide professional consultation on the drugs that their Medicare patients were using.

I believe this strong role for pharmacists will not only allow for great efficiencies in this program, but will substantially improve he quality of care in many cases.

Another issue we have been exploring for the Medicare program is catastrophic coverage for long-term care -- including both nursing home care and home-and-community-based services.

I recognize that the problems in providing adequate long term care are difficult and that the solutions may be very expensive. I regret to say it, but it may be beyond our ability to find a comprehensive solution to the long term care problem this year. But we do ourselves and the elderly a disservice unless we recognize that no catastrophic proposal in Medicare will be complete unless we commit ourselves to finding a solution in the near future.

Families should not have to face financial catastrophe in order for their loved ones to get care in a nursing home or at home.

I believe there <u>are</u> some things that we can do now.

Again, the Ways and Means Committee has made a good beginning in making improvements in home health coverage. I hope that we can do ore with a transitional care program that provides homemaker and other unskilled services for people discharged from the hospital. I hope that we can begin to address the need for a respite care benefit. And I certainly think that we can take steps to assure that the spouse of a person who enters a nursing home does not have to be impoverished in order to receive assistance from Medicaid.

And that takes me to my summary point on catastrophic coverage: the catastrophic health debate should not be confined to Medicare. Financial catastrophe will differ from one person or family to another, depending on their income. For the low-income elderly, it comes a lot sooner than for those with more resources.

Today, more than one out of four Medicare beneficiaries is poor or near-poor. These people simply cannot afford the high annual premiums, deductibles and coinsurance that they have to incur now to participate in the Medicare program. The thresholds established under the proposed catastrophic plans will be burdensome as well. Low-income aged and disabled people will not be able to afford the fifteen hundred or two thousand dollars in deductibles and coinsurance to qualify for catastrophic coverage under the plans now being considered. And, they cannot afford to pay the high price of prescription drugs. To begin to address these needs, I have introduced several proposals for Medicaid catastrophic health legislation.

These bills would improve access to Medicare benefits for the poor and near-poor. State Medicaid programs would be required to pay the Medicare premium, deductibles, and coinsurance for all elderly and disabled Medicare-eligible beneficiaries with incomes at or below the Federal poverty line, and authorized to do so for their elderly and disabled Medicare populations with incomes between poverty and 150% of the poverty level.

Another bill would give States the option of establishing a Medicaid prescription drug program for their low-income elderly. States could either offer their current Medicaid prescription drug benefit or develop a smaller chronic care drug package for the elderly near the poverty line. These people are not poor enough to qualify for Medicaid but are not wealthy enough to afford the soaring costs of prescription drugs. This kind of coverage would be an effective complement to the Medicare catastrophic drug benefit.

The last Medicaid bill is designed to address the problem of spousal impoverishment. The legislation will protect spouses when their loved one becomes too sick to stay at home and must enter a nursing home. Families should not be forced to impoverish themselves in exchange for nursing home care. We can ease this catastrophe by establishing both an adequate monthly income requirement and an appropriate assets standard for the spouse who remains in the community.

PROPOSAL FOR MANDATING EMPLOYER COVERAGE

In looking at the total picture of unmet health care needs, we must also be concerned about the 37 million non-elderly Americans with no health care insurance and the 20 million or more with inadequate coverage. The Bowen proposal does not help these people at all. I think we should be making a concerted effort to broaden their access to care.

Interestingly enough, and contrary to public perception, some two-thirds of the people without insurance are actually employed or are dependents of an employed family member. Since employer plans are the principal source of health insurance for the general public, when employers don't provide coverage people are left in desperate straits. Health insurance is often simply not available at an affordable price to these employees and families. We must find a way to address this problem.

I have been working closely with Senator Kennedy on legislation which we introduced a little over a week ago. Under this bill all employers are required to offer a minimum level of health insurance coverage to their employees, with appropriate measures to make it affordable and equitable. I believe this is an approach that is feasible now and I intend to pursue it.

HOSPITAL PAYMENTS UNDER MEDICARE

Medicare payments for inpatient hospital services will, of course, be on the agenda again this year. There is considerable concern about the effect that cuts over the last several years have had on access and quality, particularly with respect to rural hospitals and hospitals serving a large number of low-income patients.

On the other hand, there is some evidence that many hospitals, by improving their efficiency and reducing their costs, have been able to retain substantial savings on their DRG payments. I am sure that my colleagues at the Ways and Means Committee will be looking very closely at whether additional savings can be achieved for the Medicare program without impairing access and quality.

PHYSICIAN DISPENSING

I know that many of you are interested in H.R. 2168, a bill that would place limits on the dispensing of drugs by physicians and other health care practitioners for their own profit.

The Subcommittee on Health and the Environment held a hearing on this legislation on April 22, and reported a bill the next day. That bill is now pending before the Committee on Energy and Commerce.

The Subcommittee's work resulted in a number of improvements and the new version of the bill has attracted bipartisan support. A number of us have joined with Mr. Wyden as cosponsors.

As we heard from several of witnesses before the Subcommittee, the practice of physicians dispensing drugs for profit appears likely to expand in the near future. This raises clear questions of conflict of interest and possible adverse implications for the quality of care. Physicians might be tempted to prescribe drugs they had in stock, even if those might not be the first choice for a particular patient. And, all the safeguards of having a pharmacist involved would be lost.

Proponents argue that physician dispensing is pro-consumer and pro-competitive. But a patient who has already been examined and had a course of treatment prescribed is in a vulnerable position and might find it difficult to behave as an informed consumer. It is tough to tell a physician who suggests you simply buy your medicine at the front desk, "No thanks, please write out a prescription so I can shop around."

Ordinarily, this area would have been regulated by the states. However, as several witnesses testified before the Subcommittee, recent scrutiny of such regulation by the Federal Trade Commission has had a chilling effect on nearly all current state initiatives. That is why the legislation is necessary at this time.

Without adequate funding for biomedical and epidemiological work, we can only expect the epidemic to continue, here and throughout the world. Without solid public education programs, we can only expect more people to become sick and others to panic. Without adequate health financing for alternate care and for the uninsured, we can only expect the disease to become a financial crisis for public hospitals.

You know all too well the rising toll of AIDS patients in your hospitals, and you can speak out on these issues. AIDS clearly will affect all of the Nation's health care system. Health care professionals must be vocal and active to provide the framework for our national response. You must also be ready to combat the hysteria and the short-sighted responses that will come. If this disease generates only a moralistic debate, rather than one on medicine and health care, all of the Nation will lose.

CONCLUSION

Our task this year will not be easy. The budget is tight. The problems and needs are growing. I look forward to working with you to resolve these issues as thoughtfully and responsibly as possible.